Central **LHIN**

Caring Communities – Healthier People: Making a Difference

2007-2008 Annual Report

Ontario
Local Health Integration Network

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Information included in this report as of March 31, 2008

Census Subdivisions in the Central LHIN

Central LHIN, which encompasses the majority of York Region, as well as sections of north Toronto and south Simcoe, is home to approximately 1.6 million people, or about 12.9 percent of the population of Ontario.

Though by geography we are not the largest LHIN in the province, we are the most populous, the fastest-growing and the most diverse. These factors are both strengths and challenges to planning and delivering services.

Census Subdivisions are municipalities or areas deemed to be equivalent to a municipality for statistical reporting purposes (for example, as an Indian reserve or an unorganized territory).

Ontario
Local Health Integration Network

Our Mandate

Our Vision, Mission and Core Values

OUR VISION:

OUR MISSION:

OUR VALUES:

Our Mandate

Health services in Ontario have long been fragmented, with health service providers often delivering care in isolation of one another. People must navigate a complex system, often without adequate support and guidance. And despite health care spending that has continued to grow, our health system is strained. Through their mandate to plan, coordinate, integrate and fund local health services, LHINs will address these issues and make changes in our health system that truly make a difference in our communities.

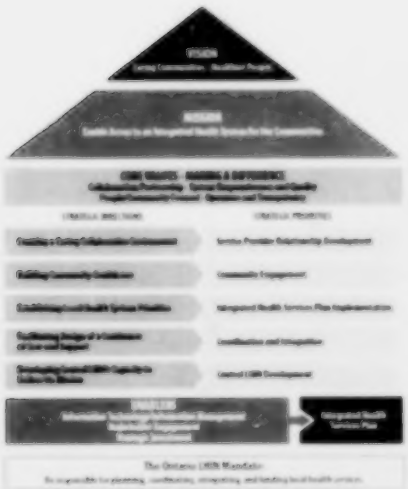
Our Vision, Mission and Core Values

Central LHIN's Vision, Mission, and Core Values were developed with input from our health service providers and community stakeholders, our Board and our staff. They serve to guide us as we work towards a health system that reflects and meets the needs of the people in our LHIN.

OUR VISION: Caring Communities – Healthier people

OUR MISSION: Enable Access to an Integrated Health System for our Communities

OUR VALUES: Collaboration and Partnerships, System Responsiveness and Quality, People and Community Focused, Openness and Transparency



Message from the Chair and CEO

Over the past year, Central LHIN has worked to implement our Integrated Health Service Plan, to build our relationships with our health service providers and other stakeholders, and to establish the foundation for an effective, transparent and accountable organization.

Our Plan, with its seven priorities, was developed through an extensive consultation and engagement process at the community level, and it was the lens through which we continued to view and evaluate our planning and engagement activities, and funding decisions in 2007-08.

We also created many opportunities over the last year to ask ourselves and our health service providers, "How can we work together more effectively?" Building relationships with our partners who are delivering services in our communities, fostering linkages and alignment amongst them, and promoting collaboration is at the heart of how we are working to build a stronger, more sustainable health system. Central LHIN is fortunate to benefit from health service provider partners who have, with interest and enthusiasm, taken up the challenge of helping us answer that question.

Continuing to engage our ethno-culturally diverse communities in meaningful conversations about local needs is another key to what we've achieved in the past year. In 2007-2008 we established our Diversity and Inclusion Advisory Network. We also met with thousands of people, talking with them in some of the many languages that are spoken in our LHIN. We asked about their needs, shared information about our plans to date, and talked about how to bring new and fresh perspectives to our planning tables. Most of all we listened, and we have heard that we are heading in a positive direction, with more yet to be done.

Working in the health system is complex and demanding. Our achievements over the past year have only been possible through the commitment of our board members and staff. We have worked hard to build a team of individuals who, through their passion and dedication have helped us make a difference in the local health system. We thank each of them for their tremendous contribution to our success in 2007-08, which are outlined in greater detail in the rest of this Annual Report, and we look forward to even greater accomplishments in the coming year.

Ken Morrison
Board Chair, Central LHIN

Hy Eliasoph
CEO, Central LHIN

June 30, 2008

Ontario
Local Health Integration Network

Making Changes in the Health System: Making a Difference

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by Ontario's provincial government to plan, co-ordinate, integrate and fund health services at the local level.

Through its Integrated Health Service Plan (IHSP), Central LHIN is dedicated to making a difference by improving the accessibility, coordination, quality and efficiency of our health system, to help people lead healthier lives.

Governed by the *Local Health Services Integration Act*, Central LHIN received its full funding authority and responsibility on April 1, 2007. The significance of this milestone for all LHINs in the province cannot be overstated as it marked the moment when our carefully laid plans and preparations could be put into action.

Since then, with a 1.5 billion dollar budget to allocate in the most efficient and effective ways possible across 140 health programs, a mandate to assume (and in some cases negotiate new) the accountability agreements of 96 health service providers, the past year has been one of transformation, dedication, commitment and plain hard work.

Our achievements and accomplishments in 2007-08 have been realized through building relationships with, and fostering collaborations amongst our health service providers, keeping our community partners involved in our planning and decision-making, beginning to implement our IHSP and working to make changes in the health system that have a meaningful impact in our communities; changes that truly make a difference.

Our Contribution to the Healthcare System

Additional Services:

- ✔ 4,414 more cataract surgeries are performed
- ✔ 9,914 more cardiac procedures are performed
- ✔ 1,310 more hip and knee joint replacements are performed
- ✔ 567 more Cancer surgeries are performed
- ✔ 19,060 more MRI hours have been added
- ✔ 1,538 more CT hours have been added
- ✔ 30 more convalescent care beds and alternatives to long-term care placements

Improvements to Healthcare:

Wait time Reduction:

- ✔ Cataract surgery waits have gone down by 39.1 percent
- ✔ Hip replacement waits have gone down by 38.9 percent
- ✔ Knee replacement waits have gone down by 16.5 percent
- ✔ CT scans waits have gone down by 47.5 percent

Service Integration:

- ✔ Service innovation, integrated service delivery and improved hospice palliative care through Central LHIN's Palliative Care and End-of-Life Care Network
- ✔ E-referral project to support single plan of care for shared clients

Initiation of New Services:

- ✔ Cultural Competency Project to assist health service providers enhance their cultural competence in the areas of mental health governance, policy and service provision
- ✔ ColonCancerCheck – cancer screening program
- ✔ Doorways to Care – a service coordination and navigation model designed to make it easier for seniors, caregivers and families to access services in Central LHIN
- ✔ Community Care Resources – partnered with health service and community partners to develop a consumer-friendly, web-based information and referral tool at http://www.toronto.communitycareresources.ca/
- ✔ Plans for a 10-bed hospice for York Region

"LHINs are changing the way our health care system is managed. They will engage local residents in the planning and delivering of health care, to create even better access to quality care and reduce wait times."

George Smitherman, Minister of Health and Long-Term Care on LHINs assuming full authority and responsibility on April 1, 2007

Building Local Governance

Central LHIN Board of Directors

Kenneth A. Morrison, Chair

Tenure: June 2, 2005 — June 1, 2008
(Reappointment Pending)
Location: Newmarket
Committee/Work Group Responsibilities:
- LHIN Officer
- End-of-Life
- Governance Councils
- LHIN Chairs Group

Ken Morrison is president of R.V. Anderson Associates Limited, a consulting firm engaged in the provision of professional engineering, operations and management services for infrastructure and environmental projects. Morrison had a long association with the North York General Hospital. He joined the hospital's foundation board of governors in 1991, serving as chair of the planned giving committee, and then as treasurer and finance committee chair. In 1994, Morrison joined the hospital's board of governors and served as Vice-Chair from 1996 to 2000, before being elected to serve as Chair from 2000 to 2005.

Arthur W. Walker, FCA, Vice-Chair

Tenure: June 2, 2005 — June 1, 2008
(Reappointment Pending)
Location: Bradford
Committee/Work Group Responsibilities:
- Accountability Agreements
- Knowledge Transfer
- Performance Framework
- Local Scorecard
- CLHIN/IHSP Scorecard
- Funding – Decision Framework for Strategic Investment

Arthur Walker continues a long-established senior governance role in the delivery of health care in the Province of Ontario. He is a former Governor and Treasurer of the Brantford General Hospital, a former Governor and Chairman of Toronto's North York General Hospital, a former Chairman of the North York General Hospital Foundation, and prior to his appointment as Vice-Chair of Central LHIN was Director of the Southlake Regional Health Centre and of the Southlake Residential Care Village in Newmarket, Ontario. He has had broad experience as Chair, CEO, Director of numerous public and private companies – currently serving as Chairman of the Board of Calyx Transportation Group Inc., Chairman of the Board of Cryofitz Inc., and as a Director of CEO America Inc., CEO UK Inc and Creation Technologies GP Corporation.

Sandy Keshen, Board Secretary

Tenure: June 2, 2005 — June 1, 2008
(Reappointment Pending)
Location: Richmond Hill
Committee/Work Group Responsibilities:
- Long-Term Care (incl. Wait Times and Alternate Levels of Care)
- Mental Health and Addictions
- Neurological Services
- Health Human Resources
- Diversity and Inclusiveness
- Aboriginal

Sandy Keshen is President and CEO of Reena, a social services agency that supports individuals with developmental disabilities and their families to be fully integrated into the community. Keshen is Co-Chair of the Ontario Partnership on Aging and Developmental Disabilities. She has served as Chair of the Metro Agencies Representative Council and Chair of the Ontario Association on Developmental Disabilities. Keshen was also a board member at Whitby Psychiatric Hospital, and a member of the Vaughan Hospital Task Force.

Colin Benjamin

Tenure: January 5, 2008 — January 4, 2011
Location: North York
Committee/Work Group Responsibilities:
- Seniors and Specialized Geriatric Services
- Long-Term Care (incl. Wait Times and Alternate Levels of Care)
- Access and Coordination
- Quality

Colin Benjamin is currently the Chair of CareWatch Toronto, a voluntary organization dedicated to ensuring the quality of community-based long-term care. Prior to his retirement, he served as Assistant Vice-President, Research Administration at the University HealthNetwork. He holds a Masters of Health Services Administration from University of Kings College/ Canadian School of Management. He is a member of the Canadian College of Health Executives and the Society of Research Administrators. He has served on the City of North York Board of Health and North York Community Care Access Centre Board of Directors.

Anne Marie Dalimonte

Tenure: January 5, 2008 — January 4, 2011
Location: Woodbridge
Committee/Work Group Responsibilities:
- Mental Health and Addictions

Anne Marie Dalimonte was Vice President of a retail food chain for 17 years. For the past 11 years, she has served as the Executive Director of a not-for-profit day care organization which serves over 500 families. Her involvement in community affairs reflects her wide range of interests: president of a parent-teacher associatio vice-president of a figure skating club, and membership in her local ratepayers' organization. A graduate in business, she was one of just 25 Canadian representatives at the Duke of Edinburgh's Commonwealth Study Conference in 1992.

Monique Moreau

Tenure: January 5, 2006 — February 4, 2010
Location: Everett
Committee/Work Group Responsibilities:
- Family Physicians

Monique Moreau has practiced family medicine in Alliston since 1997. Other activities include being a coroner, surveying for Canadian Council on Health Services Accreditation, and being an examiner for the College of Family Physicians of Canada. Previous experience includes teaching family medicine at the University of Toronto and being a preceptor for allied health trainees. Board experience includes Stevenson Memorial Hospital from 2003 to 2006, as well as St.Michael's Homes, Toronto, and Les Residences Lyne Ferguson in New Brunswick.

Raksha M. Bhayana

Tenure: May 17, 2006 — May 16, 2008
Location: Thornhill
Committee/Work Group Responsibilities:
- Diversity and Inclusiveness
- Communications
- Aboriginal

Raksha Bhayana is Principal of Bhayana Management and is responsible for managing investment portfolios of related companies. Prior to this, she was Director of Business Development and Information Systems at Inscape, Director of Professional Services at Family Service Association of Toronto and held various positions at Dellcrest Children's Centre, including Director of the Child and Family Clinic. Bhayana currently sits on the Board of Trustees for the United Way of Greater Toronto. She has recently been nominated to the Board of Unicef Canada. She is an Associate Member of the International Forum for Child Welfare. She has served as a community

member of the Operations Committee for York Central Hospital, Toronto Steering Committee for the Ontario Early Years Centres and on the boards of the Family Service Association, Surrey Place Centre and the Ontario Association of Professional Social Workers. She holds a Master of Social Work from the University of Delhi (India).

Eugene Cawthray

Tenure: May 17, 2006 — June 16, 2010
Location: King City
Committee/Work Group Responsibilities:
- Neurological Services
- Information Management/Information Technology/e-Health
- Audit (Chair)

Eugene Cawthray is President of Cawthray and Associates Inc., advising companies on their business development strategies. His current assignments are with EDS Canada, a technology management and outsourcing firm. Prior to this, he served as a special advisor for procurement transformation with the Federal Government in Ottawa. Cawthray has also held executive positions at IBM Canada Ltd., Enlogix Inc. and INTRIA Corp. He has served on the boards of York Central Hospital and of the Canadian National Institute for the Blind (CNIB) in Ontario, acting as Chair for two years. Today, he also serves on the Pension Advisory Committee for the CNIB.

Elaine Walsh

Tenure: June 17, 2006 — June 16, 2010
Location: Unionville
Committee/Work Group Responsibilities:
- Chronic Disease
- Health Human Resources
- Family Physician Advisory Group

Elaine Walsh held several positions at the Scarborough Hospital from 1999 to 2005 including Associate Director of Family Medicine and Community Services, Director of Diabetes in-patient and outpatient Programs, Director of Disease Prevention and Health Promotion, and Director of Patient Education. Prior to this, she worked for the York Region Health Department as Manager of Adolescent Health and School Program. In addition, she has worked at the Scarborough Grace Hospital as director of The Family Wellness Centre, and the York Region District Health Council as a health planner. Walsh has served on various committees and boards including Canada Prenatal Nutrition Program, Scarborough Program Advisory Committee, York Region Child Poverty Action Group and Addiction Services for York Region. She was also a founding volunteer of the Hospice Markham Stouffville. She holds a Bachelor of Science in Nursing from McGill University and a Master of Education from the University of Toronto. She is a member of the College of Nurses of Ontario.

Annual Board Remuneration

The aggregate remuneration for members of the Board of Directors for fiscal 2006/07 was $122, 325.

LHIN-Health Service Provider Toolkit on Governance Relationships in Voluntary Integration Initiatives

Central LHIN, along with four other LHINs – Central East, Central West, Erie St. Clair and the South East LHINs – representatives from health service providers and the Ministry of Health and Long-Term Care, formed a project steering committee to develop a LHIN-health service provider governance toolkit. The group was struck to develop an understanding for LHIN expectations, and tools that would assist health service providers with their voluntary initiatives.

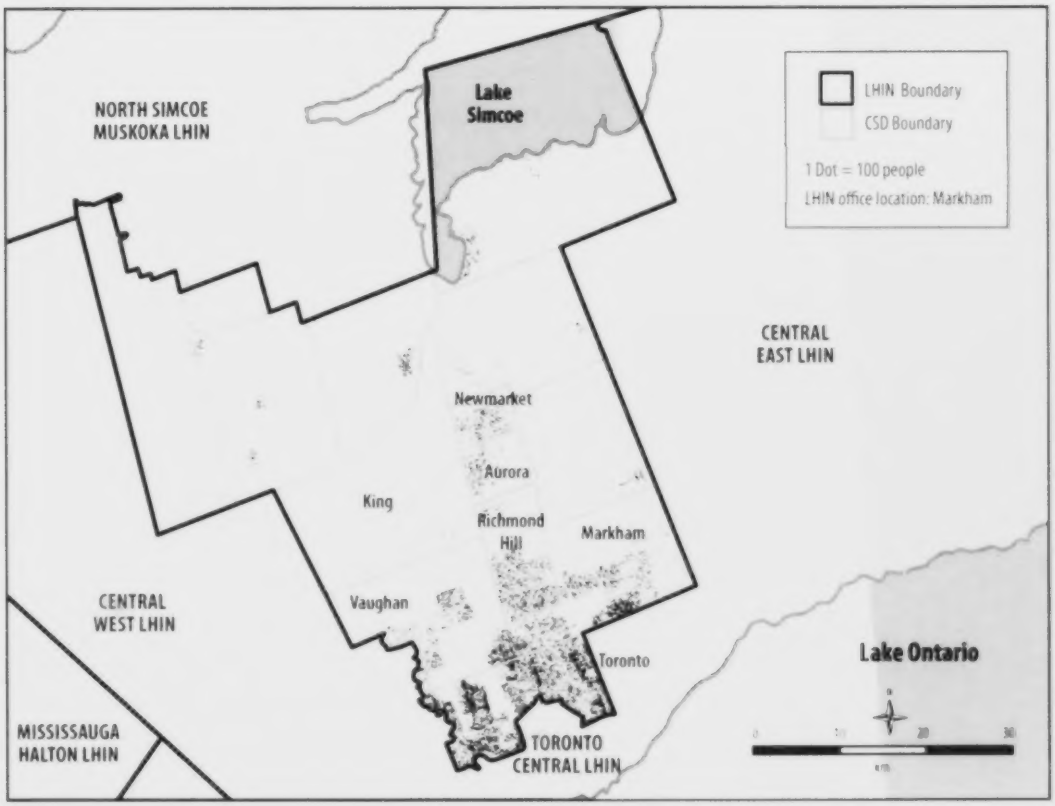
Draft one of the toolkit was completed in late winter 2007 and reviewed by steering committee members, their associations, LHIN/Board chairs and CEOs. The toolkit is expected to be completed and made available to health service providers by July 2008.

Our LHIN values transparency and accountability. Members of the public are welcome to attend our Board meetings, held on the fourth Tuesday of each month. Please visit our website at **www.centrallhin.on.ca** for more details.

Growth, Aging and Diversity: A Look Inside our LHIN

Population Profile

Home to over 1.6 million people, the Central LHIN is the most populous LHIN in Ontario, representing about 12.9 percent of the province's population. Our residents live primarily in neighbourhoods in north Toronto, the communities north of the city commonly known as the "905" area and along the Highway 400 corridor.



While our residents are generally younger and more educated compared to the province, some unique local challenges will require innovative solutions as we plan for our health service needs today and in the future.

GROWTH – The Central LHIN is one of the fastest growing regions in the province with an annual growth rate over the last 10 years of 3.3 percent. This means that, on average, the population has increased by 106 new residents (through birth or immigration) every day in the past decade. In the next 10 years, our LHIN will continue to experience significant growth, with a projected population in 2018 of almost 2 million people, further stretching our health system and its resources.

AGING – Over the next 10 years, the Central LHIN will see a massive increase in the number of seniors in comparison to today. Seniors 65+ are the fastest growing demographic in our LHIN. Central LHIN already has the third highest number of seniors of all LHINs in the province, and by 2017 it is projected that we will have the highest numbers of seniors 65+ of all LHINs in Ontario. Given that age is the greatest predictor of increased illness and use of health services, we will continue to focus on building our capacity to serve seniors in a proactive and wellness-focused manner.

DIVERSITY – The residents of Central LHIN are more ethnically diverse in comparison to other LHINs and the province, with 36 percent of our population identifying themselves as visible minorities. Within our LHIN, North Toronto, Markham and Vaughan are the communities most likely to face challenges providing ethno-culturally sensitive and appropriate services to meet the needs of our richly diverse population.

Select Demographics of Central LHIN Population compared to Province of Ontario

Indicator	Central LHIN	Province
Visible Minorities	36%	19%
Immigrant Population	46%	27%
Recent Immigrants (1996-2001)	10%	5%
No knowledge of French or English	4%	2%
Aboriginal identity Population	0.3%	2%
French speaking	1.3%	4.8%
Seniors 65+	11.6%	13.3%

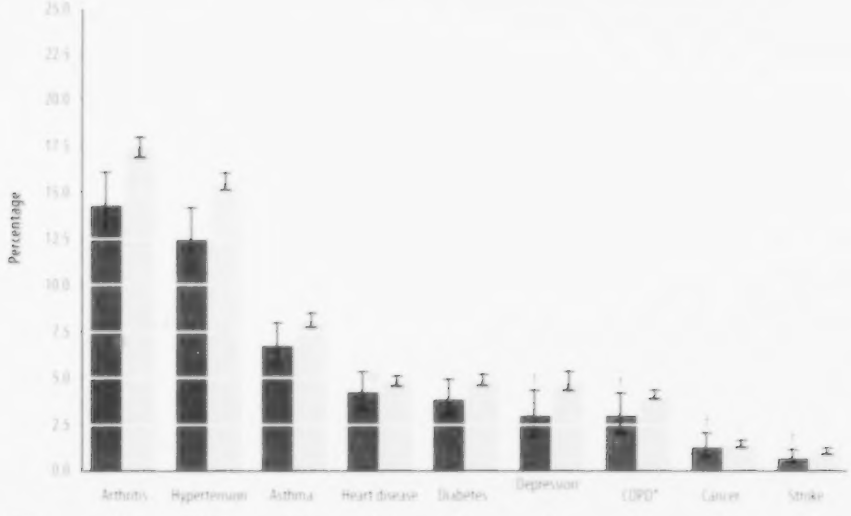
Health Profile

The Central LHIN has a relatively healthy population, with lower incidences of chronic diseases and conditions like high blood pressure, diabetes, heart disease, arthritis and asthma, relative to provincial rates (see *Chart 3: prevalence of selected chronic conditions, population 12+*).

This is likely related to three factors. First, residents in our communities generally practice positive healthy behaviours (see *Chart 2: health practices, population 12+*). Second, we currently have a slightly younger overall population. Third, our population reflects positive determinants of health characteristics, such as a strong socio-economic status and high educational attainment.

However, as outlined in the section on Aging above, this is about to change dramatically over the next decade. So, as our LHIN's population ages, there will be more people with chronic conditions and the changes in associated service needs. This will require further planning to address our future healthcare requirements in order to improve the quality of life for those living with various health conditions.

Chart 3: Prevalence of selected chronic conditions, population age 12+



	Arthritis	Hypertension	Asthma	Heart disease	Diabetes	Depression	COPD*	Cancer	Stroke
Central	14.2*	12.4*	6.8	4.3	4.0	3.1	3.1	1.5	0.9
Ontario	11.2	11.4	8.0	4.8	4.6	4.8	4.1	1.5	1.1

Chart 2: Health practices, population age 12+

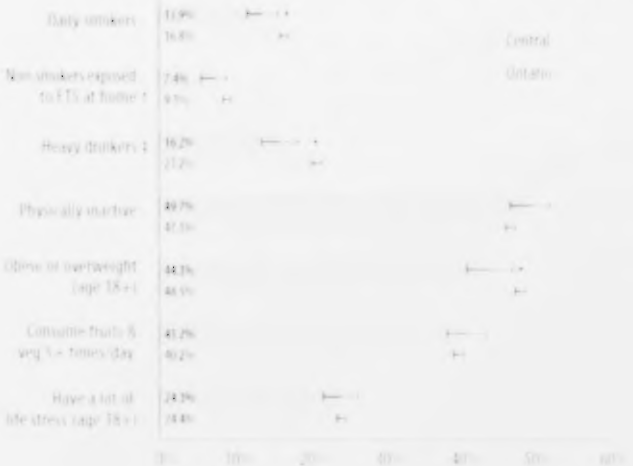
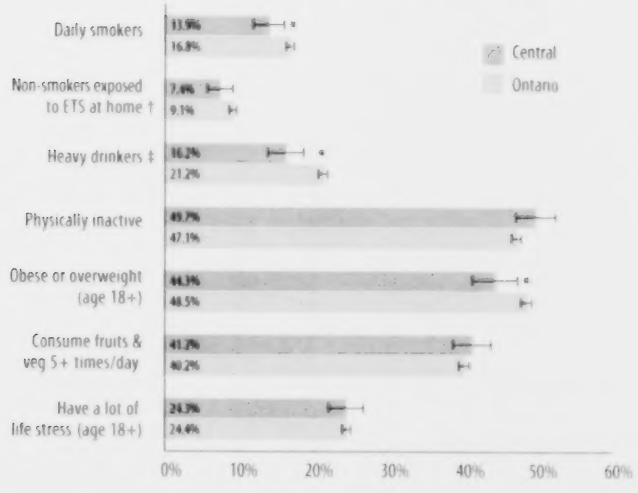


Chart 3: Prevalence of selected chronic conditions, population age 12+

	Arthritis	Hypertension	Asthma	Heart disease	Diabetes	Depression†	COPD‡	Cancer	Stroke
Central	14.2*	12.4*	6.8	4.3	4.0	3.1	3.1	1.5	0.9
Ontario	17.2	15.4	8.0	4.8	4.8	4.8	4.1	1.5	1.1

Error bars represent 95% confidence intervals (CIs)
Source: 2005 Canadian Community Health Survey and 2002 Canadian Community Health Survey (Mental Health and Well-being), Statistics Canada, Ontario Share File
† Prevalence of depression is calculated for those age 15 years and over
‡ COPD includes chronic pulmonary disease, emphysema and bronchitis and is reported for the population aged 30 and over
§ Coefficient of variation 16.6% to 33.3% - interpret with caution
* Significantly different from provincial average based on assessment of 95% confidence intervals

Chart 2: Health practices, population age 12+



† ETS - environmental tobacco smoke (second hand smoke)
‡ as a proportion of current drinkers
* Significantly different from provincial average based on assessment of 95% confidence intervals
Data Source: Canadian Community Health Survey, 2003

Connecting with Our Communities

Our commitment to community engagement

Community engagement is an integral part of Central LHIN's activities. By listening to our residents, local health service providers and strategic partners, and by seeking input into our plans, we are supporting community-level participation in health system decision-making. Through our Stakeholder Engagement Strategy, we have and will continue our efforts to reach greater numbers of people in our LHIN to include them in meaningful discussions around what changes are needed in our health system, and how best to make them.

Encouraging the conversations

Over the past year, Central LHIN used a variety of engagement methods, across all geographic areas, to target three key stakeholder groups including: ethno-cultural /faith /multilingual groups, business leaders, and educators. Other sessions were held with particular stakeholders relative to specific opportunities such as the Aging at Home strategy, and the planning for hospital services in Vaughan.

We also met regularly with our health service providers to implement IHSP priorities, discuss other health-related initiatives, and negotiate accountabilities. There are over 30 networks, advisory groups, workgroups and committees led by Central LHIN, and hundreds of providers, community members, consumers and physicians are represented on these groups.

We also engaged the broader community in separate meetings with other 100 non-health service providers and other groups not funded by our LHIN.

In total from April 2007 – March 2008 we met with close to 2,000 residents, health service providers, politicians, grassroots organizations and other interested individuals on health priorities and initiatives in our LHIN.

What we heard

Some of the themes we heard include concerns over:

- Lack of long-term care beds
- Need for more services for seniors
- Access to family physicians
- Wait times
- Lack of awareness about available health services
- Challenges in providing ethno-culturally sensitive health services
- Need for more focus on prevention and wellness promotion
- Health human resource shortages

Connecting with our Aboriginal population

In early 2008, the MOHLTC provided LHINs with additional annualized funding to support community engagement with the Aboriginal population. Central LHIN used its allocation to contract the Noojimawin Health Authority, an Aboriginal health planning organization based in Toronto, to: identify the health priorities of the LHIN's Aboriginal population; identify key contacts within these communities; determine the most effective way to engage these key people; and provide information about the LHIN.

This engagement and consultation with community-level Aboriginal organizations has strengthened our mutual understanding of one another, and produced some key themes that will now form the basis for future planning activities in Central LHIN with regard to our Aboriginal population.

Another key outcome is access to data regarding Aboriginal health in our LHIN, which can be used to ensure we focus on appropriate goals as we work to support the health needs of this community.

Top five Aboriginal health issues in Central LHIN (Source: Noojimawim Health Authority)

1. Diabetes (Types I and II) **2.** Mental Heath **3.** Hypertension **4.** Musculoskeletal and Locomotor **5.** Respiratory disease

Connecting with our French speaking residents

1.3 percent of Central LHIN's population identify themselves as French speaking. In the past year, we held two key sessions around French language services in our LHIN. The first was a planning session attended by Réseau Franco-Santé du Sud de l'Ontario and the Société Santé en Français (organizations dedicated to ensuring francophones have access to quality health services in French), the regional consultant for French Language Health Services for Central LHIN, and Central LHIN staff. The second was a presentation made by Central LHIN to the Toronto Region French Language Health Services Planning and Support Committee. The goal of both sessions was similar: to share information around Central LHIN's activities in this area, to discuss the current status of French language services, including needs and gaps, and to talk about how to achieve a shared vision for French language services in the LHIN.

Assessing our community engagement activities

Community engagement is a key element of the Central LHIN's legislative framework. Section 16 of the *Local Health System Integration Act* (Bill 36) mandates Local Health Integration Networks to engage with their communities. Community engagement means developing meaningful dialogue between health consumers, citizens, health service providers and the LHIN. Community engagement is also a process to improve communities by identifying and addressing local issues, ideas, concerns and opportunities.

Examples of unique community engagement opportunities which took place in 2007/08 include a Diversity and Inclusion Workshop, a Career Fair, an Integration Knowledge Exchange sessions, an End-of-Life Networking Day, a Concurrent Disorders Workshop, Aging at Home Community Roundtables, and an IHSP Leadership Summit. Consumers were represented at several of these events as are members of the various Networks and Advisory Groups. Evaluations of these events demonstrated a high level of satisfaction according to the feedback that the LHIN received from participants.

The Central LHIN believes our early efforts in community engagement have succeeded in creating greater collaboration and integration among service providers. Additionally, there is greater focus on inter-sectoral planning and cooperation with a focus on population health issues of specific target populations within geographic areas.

By engaging with our communities, a foundation has been developed and a shared vision created where health service providers are working together to achieve our collectively developed IHSP goals.

For more on our community engagement activities, visit **www.centrallhin.on.ca**.

Our community engagement goals

Focus on the people who use health care – We will place the client at the centre and engage directly with those who are most knowledgeable about their experience and degree of satisfaction with health care services – the residents themselves.

Enhance local accountability – We will enhance accountability at the local level by providing direct opportunities for input into decision-making.

Balance priorities – Informing and engaging the public is the best approach to address stakeholder needs and responsibilities. We will also foster a shared sense of responsibility for achieving balance amongst competing priorities.

Develop system capacity & sustainability – Communities are the best source of knowledge about their own needs and their own solutions. We will draw on this knowledge and capacity, to identify needs and gaps, and help build sustainable, long-term solutions.

Working with our Health Service Providers

Making Positive Changes through our Integrated Health Service Plan

Our Integrated Health Service Plan (IHSP) has seven priorities, identified during an extensive consultation and engagement process with thousands of individuals at the community level. Keeping our priorities top of mind determined where we could best direct our resources in 2007-08.

Seniors

Seniors are the fastest growing segment of Central LHIN's population. Consequently much of our attention over the past year has been focused on this priority. Led by the Seniors Advisory Network, Central LHIN moved ahead with initiatives to address barriers to access for seniors' services including: under-serviced geographic areas in our LHIN, transportation shortages, system navigation difficulties, lack of education and sensitivity around the unique needs of seniors from ethno-culturally diverse communities, and capacity issues in the community support service and long-term care sectors. Several examples include:

- **CONVALESCENT CARE** – expansion of the LHIN's convalescent care capacity through conversion of 30 long-term care beds to convalescent care beds,
- **ALTERNATIVES TO LONG** – Term Care Placement – an initiative to fund services for individuals waiting for long-term care home placement in order to allow them to age at home as long as possible,
- **TRANSPORTATION** – expanding programs that provide seniors with agency or volunteer-based transportation to medical services,
- **SENIOR FRIENDLY** – encouraging hospitals to adopt "senior friendly" practices, and
- **SPECIALIZED GERIATRIC SERVICES** – expansion of programs such as geriatric emergency management in emergency departments and assessment teams for frail seniors.

Some of the above programs are being advanced through Aging at Home, a three-year provincial strategy to help seniors remain in the community longer. For a more detailed look at our Aging at Home plans, see *Special Initiatives* on page 20).

Seniors stats - CLHIN and provincial

Seniors 65+ currently represent 11.6 percent of the LHIN's total population, or about 190,000 out of 1.6 million people

In five years Seniors 65+ will represent 12.6 percent of Central LHIN's population or about 230,000 out of 1.8 million

Seniors 65+ currently represents 13.3 percent of Ontario's total population, or about 1.7 million out of 12.9 million people

In five years Seniors 65+ will represent 14.5 percent of Ontario's population or about 2.0 million out of 13.8 million people

Mental Health and Addictions

A lot of progress has been made in this HSP priority over the last year, thanks to the dedication of Central LHIN's Mental Health and Addictions Network and its corresponding workgroups. Here are a few of the highlights of what they have accomplished:

- supported the development of a Consumer Survivor Network to ensure the collective voice of survivors in Central LHIN activities,
- implemented a Cultural Competency Project to assist health services providers enhance their cultural competence in the areas of governance, policy, and service provision,
- sponsored a Concurrent Disorders Conference for health service providers, and
- liaised with health service providers to ensure compliance with ConnexOntario.

Most recently, the Communications Workgroup launched a mental health and addiction information section on the Central LHIN website for health service providers and the general public (To learn more, read our "HSP available on **www.centrallhin.on.ca**).

Chronic Disease Management and Prevention

In recognition of the serious personal, economic and social impacts of chronic disease, the Central LHIN established the Chronic Disease Management and Prevention Advisory Network, and has moved ahead with initiatives including:

- a chronic disease self-management capacity building initiative for primary health care professionals, and
- an education initiative to increase collaboration and share best practices in the continuum of care for patients with chronic diseases.

Most recently, phase one of a Community Outreach Collaborative was completed. The collaborative will improve client outcomes by reducing barriers to accessing health care for seniors with diabetes currently living in rural and remote areas of the Central LHIN, through outreach clinics and use of tele-monitoring strategies.

Neurological Services

A significant proportion of the population is affected by or provides care to individuals with neurological diseases, disorders and illnesses. Over the past year, the Central LHIN Neurological Services Advisory Network has focused its efforts on activities to improve the continuum or care for neurological services in our LHIN by:

- undertaking a strategy to prevent unilateral service changes and withdrawals in accordance with the LHIN's Integration Decision Process and Criteria, the Local Health System Integration Act and the HAPS Guidelines,
- specifying the neurological diseases, disorders and injuries affecting the diverse ethno-cultural population in our LHIN to inform planning activities, and
- strengthening system navigation resources for seniors through beta testing the Community Care Resources service inventory database to ensure all areas of service were included and that resources, contacts and referrals could be identified when searching the database.

Emergency Services

Shortages in primary care physicians, a lack of alternatives to emergency services, and the pressures of a growing population exert a continuing strain on emergency services in Central LHIN, which is reflected in both the challenges involved in managing these services and the ability of patients to access them in a timely manner.

Over the past year, Central LHIN recruited an Emergency Department Lead. The primary focus for this individual is to:

- coordinate the LHIN's efforts in this area with that of ongoing provincial initiatives, and
- meet with the physician leaders of the Emergency departments of all Central LHIN hospitals to begin identifying challenges and solutions.

Additionally, our Lead will convene an Emergency Services Advisory Network to review and assess the range of factors contributing to the effective and timely delivery of emergency services to formulate a comprehensive strategy to improve access, quality and system integration.

Wait Times

As anyone who has had to wait for care and services for themselves or a loved one can attest, it can be frustrating and even frightening. Lengthy wait times for procedures such as cataract surgery, or hip and knee replacements can also negatively affect a patient's ultimate outcome. Those are just two reasons why wait times are both a provincial focus and one of our HSP priorities.

In 2007-08, Central LHIN continued to allocate funding for wait times to areas where it was most needed. Working in alignment with the provincial Wait Times Strategy, we've brought wait times in Central LHIN down for a range of critical procedures including: Bypass surgery, Cataract Surgery, Hip replacement, Knee replacements, MRI exams and CT scans. Our allocations have in particular resulted in higher volumes for cataract and hip/knee replacement procedures, and more hours for MRI and CT scans. (For data on our wait times, see *Performance*, page 25.)

Through a strategy developed by our Wait Times Strategic Planning Group, Central LHIN is supporting a move towards implementation of two high volume cataract centres – one in the north and one in the south area of the LHIN – which would result in a number of positive benefits for patients, including better clinical outcomes, shorter overall wait times for surgery, and enhanced capacity within the system to deliver more surgeries each year.

As Central LHIN continues to promote and implement these types of proactive solutions, as well as monitor and track our progress in this area, we are confident our residents will continue to benefit from reduced wait times in our LHIN.

Over the past year, $1,273,271 dollars has been invested through the Wait Time Strategy for additional procedures in Central LHIN hospitals including:

Procedure	Incremental* funding	Resulting in an additional
Cataracts	$ 3,118,500	4,414 cataract surgeries
Cardiac	$ 9,983,398	9,914 cardiac procedures
Hip and Knee Joint Replacements	$ 9,086,238	1,310 hip and knee joint replacements
Cancer	$ 3,745,035	567 Cancer surgeries
MRI	$ 4,955,600	19,060 hours
CT	$ 384,500	1,538 hours

*Incremental funding is one-time funding allocated to a hospital to provide a certain number of additional procedures within a specific year.

Cancer Care

Central LHIN has established a Cancer Care Services Steering Committee, with representatives of Cancer Care Ontario, Southlake Regional Health Centre, and other Central LHIN hospitals and health service providers. The Steering Committee's objectives include fostering partnerships among cancer care providers to support integrated care and services for patients, and working collaboratively to implement the Ontario Cancer Plan in ways that are most appropriate at our local level.

Most recently, the Steering Committee has:

- endorsed a project to develop a hospital-wide digital storage and retrieval system that will allow health service providers at Southlake to access and view patient x-rays, ultrasounds, mammograms and other images online, and
- supported the new province-wide cancer screening program ColonCancerCheck through partnerships and promotions within various sectors in our LHIN, and public service messages on local transit.

The Committee is also working to strengthen the relationship between Southlake and the Princess Margaret Hospital, a centre of excellence that provides one of the largest comprehensive cancer programs in the world in order to support Southlake as it develops its new Regional Cancer Centre. Having established a mutually beneficial partnership enables both centres to work together to share best practices and to ensure a seamless provision of services for patients who move between facilities in the course of their treatment.

Supporting Diversity and Inclusion

Central LHIN is the most diverse LHIN in Ontario, which presents both opportunities and challenges in health services planning and funding. In 2007-08, our LHIN demonstrated its commitment to supporting diversity and inclusion by:

- Providing diversity education for board members and staff
- Hosting a diversity and inclusion workshop for health service providers
- Establishing a Diversity and Inclusion Advisory Network
- Working to address health disparities for the most marginalized populations using a Social Determinants of Health working framework
- Recognizing the need for improved access to ethno-culturally sensitive services for seniors in our Aging at Home plans
- Funding a Community of Practice initiative in the Jane/Finch area

Building on a successful program

The number of convalescent care beds in the Central LHIN is increasing by 30 beds, as two long-term care homes in the LHIN convert existing long-stay beds to convalescent beds, which provide an opportunity for seniors and others who require it to recuperate in a slow-stream, rehabilitation setting before returning home.

Funded by Central LHIN, the initiative is being guided by a steering committee that includes representatives from the long-term care facilities, the Central Community Care Access Centre, the three hospitals in the region (Markham Stouffville Hospital, Southlake Regional Health Centre, and York Central Hospital) and St. Elizabeth Health Care. The conversion was initiated in part as a result of the successes achieved by the current program at the Newmarket Health Centre, which has a high level of patient satisfaction and which has helped area hospitals by moving alternate level care patients into the program and freeing up acute care space.

"I want the staff to be recognized for their dedication and help. I was indeed privileged to be part of this program."

Edith Newman, 87 year-old Newmarket resident writing in a letter to the Minister of Health and Long-Term Care about her convalescent care stay at Newmarket Health Centre.

Integrated Health Service Plan Leadership Summit

In March 2008, Central LHIN hosted 167 health service provider board chairs and executive leads at a one-day IHSP Leadership Summit to encourage them to take further ownership in the implementation of our IHSP, and to talk about how we could work together to make this happen. The session also provided a forum for our health service providers to connect and dialogue with one another to build stronger relationships within and cross-sectors. Participants generated the day's discussion topics, which were shared broadly post-session.

Three themes emerged as particularly relevant to our future collective efforts:

- First, in order to move forward together, to think beyond the walls of our own organizations, we need to understand one another better. Spending time together and listening to what is important to each of us is one helpful way to build this understanding.
- Second, there is an incredible wealth of knowledge and experience inherent within our LHIN. This affords an opportunity for us to leverage this expertise in meeting the needs of our stakeholders and community, as we progress toward building a better health care system.
- Third, while transforming the health care system takes time and there is work ahead of us in creating a shared destiny, there is also enthusiasm and willingness among us to collaborate towards a full partnership.

"What can we, as Central LHIN health service providers, do over the next two to three years to implement our Integrated Health Service Plan?"

Special Initiatives

Aging at Home: Supporting our Vision for Seniors' Services

"Independence, autonomy, and choice for seniors in Central LHIN through an integrated, sustainable and comprehensive continuum of services, provided in an equitable, accessible and affordable manner."

CENTRAL LHIN SENIORS ADVISORY NETWORK

In August 2007, the MOHLTC announced a $700 million Aging at Home strategy aimed at providing the supports and services seniors need to live independently in the community for as long as they wish. Through Aging at Home Central LHIN will invest $106 million over three years. Seniors are the fastest growing segment of Central LHIN's population, so this funding provides a timely opportunity to create a strong integrated community care system for seniors: one that aligns with our vision for seniors' services in our LHIN.

Central LHIN submitted a directional plan for Aging at Home to the MOHLTC in October that included our three-stream planning approach:

1. Implement Aging at Home priorities identified in our Integrated Health Service Plan and Annual Service Plan
2. Build community capacity and enhance community-based care
3. Encourage creative and collaborative innovation to increase ethno-culturally sensitive access to services such as supportive housing, caregiver support and wellness, health promotion

Throughout the fall and winter we talked to over 1,000 seniors, caregivers, health service providers, seniors' organizations and other groups about Aging at Home priorities. Our meetings were held in six of the many different languages spoken in our LHIN including: English, Cantonese, Tamil, Punjabi, Russian and French.

The key themes that emerged in our engagement sessions helped shape the selection of projects for inclusion in our Aging at Home Detailed Service Plan for 2008-09, submitted to the MOHLTC in February 2008, which targets seniors with a wide range of needs including:

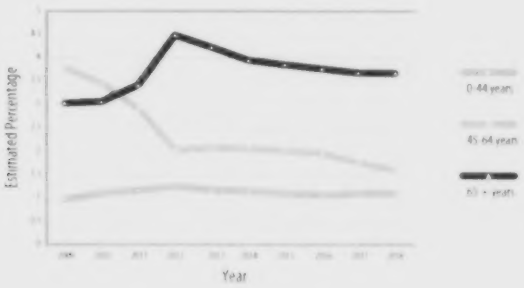
- Seniors from diverse ethno-cultural communities
- Frail seniors requiring specialized support such as diabetes and aphasia services
- Seniors living in isolation
- Seniors in need of transportation services
- Seniors with mental health needs
- Caregivers, many of whom are seniors themselves
- Seniors at risk of unnecessary emergency room use

Overall our plan will build community capacity, expand services throughout our LHIN, and promote innovation to better support our seniors today and tomorrow.

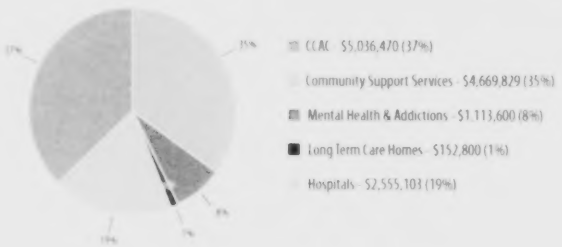
For more detail on our Aging at Home strategy, visit **www.centrallhin.on.ca**

"Many Central LHIN seniors benefit from our rich pool of dedicated volunteers. But we know volunteers can't do it all. That's why we're investing in caregiver support and education through Aging at Home."

Percent Change in Central LHIN Population Age Groups 2008-2018



2008/09 Detailed Aging at Home Funding Plan Breakdown by Sector



LHIN Urgent Priorities

In fall of 2007, the Ministry of Health and Long-Term Care announced an allocation of just over $2 million to Central LHIN from the provincial Urgent Priorities Fund to address local priorities. Our staff recommended appropriate allocations for this new funding in alignment with the priorities of our IHSP, our Annual Service Plan, and MOHLTC criteria.

Approved projects focus on a range of IHSP priorities including Seniors, Mental Health and Addictions, Wait Times, and Chronic Disease Management and Prevention.

Other projects advance the goals of IHSP enablers such as Diversity and Inclusion and Health Human Resources. Two key examples include:

- Laying the groundwork to establish a Community of Practice to build capacity in the community and among service providers to advance diversity and inclusion in health service delivery. The community of practice focuses on solutions to language barriers that newcomers face; tools, training and support for service providers; and public education on access to health services and information.
- Initiating a Health Human Resource Risk Reduction Plan to inform our health human resource planning, to identify opportunities to support the recruitment and retention of designated health professionals (for example by partnerships with local community colleges/universities), and to make recommendations to the LHIN for initiatives to address human resource risk areas related to increasing service delivery capacity.

Most if not all of our urgent priority projects support integration activities, a key mandate of the LHIN.

MOHLTC criteria for urgent priorities:

- Improves provision of services (existing or new);
- Supports integration activities focusing on improving: access, equity, health outcomes, quality of care and efficiency, and
- Demonstrates progress toward performance targets set out in the Ministry-LHIN Accountability Agreement.

Doorways to Care

Doorways to Care is a service coordination and navigation model designed to make it easier for clients (in particular seniors), caregivers and families to access services in Central LHIN. The model aims to improve linkages between providers, and to strengthen their capacity to disseminate information, make referrals and coordinate services. It also holds a special place as a milestone for Central LHIN. Doorways to Care was the first IHSP initiative approved by Central LHIN's Board of Directors in 2007-08.

To date the Doorways to Care workgroup has identified existing barriers to system access and navigation, and developed recommendations to remove or reduce those barriers, including a toll-free central access number for seniors, coupled with translation services to accommodate the needs of diverse populations within Central LHIN, and the assignment of a lead individual within the network of providers so that clients are never on their own as they navigate the system. The draft implementation plan includes designing and testing the various elements of the model in anticipation of a launch later in 2008.

Planning for Health Services in Vaughan

In July of 2007, after a request from the Ministry of Health and Long-Term Care, Central LHIN took on the challenge of conducting a health service needs assessment for the Vaughan community. Working with the Vaughan Healthcare Foundation, and the consulting firm of Deloitte, Central LHIN conducted an extensive stakeholder consultation process and needs assessment process that resulted in findings and recommendations outlined in our report entitled Service Needs Assessment for Identification of Vaughan Hospital Services. In all we spoke to over 500 health service providers and members of the general public during the process, to gather and share information, and to validate our findings. We submitted our final report to the Ministry of Health and Long-Term Care on March 31, 2008 and it is also posted on our website at **www.centrallhin.on.ca**.

E-Health Collaboration

Technology is one of the enablers identified in our IHSP. In November of 2007, Central LHIN joined forces with Toronto Central LHIN to collaborate on e-Health initiatives such as:

- participation on the LHIN e-Health Leads Council, a provincial group formed in part to provide support and a forum for discussion and sharing of information around LHIN e-Health objectives,
- work on a refresh of the LHIN e-Health strategies (first developed by the LHIN e-Health Leads Council) by merging the two existing strategies and updating the overall approach based on recent changes in the e-Health environment,
- implementing Smart Systems for Health Agency connectivity and secure email for community support service agencies, and
- partnering with the Central, South East and Toronto Central Community Care Access Centres, as well as health service providers and community partners, to develop a consumer-friendly, web-based information and referral tool called Community Care Resources (available online at **http://www.toronto.communitycareresources.ca**.)

Smart Systems for Health Agency, formed and funded by the Ontario government, is the enabling force behind a province-wide information technology infrastructure delivering world-leading e-Health solutions.

Hospice Palliative Care

Central LHIN's Hospice Palliative Care Network was developed to provide collaborative leadership to plan, coordinate and evaluate comprehensive palliative care services for residents of our LHIN. The network seeks to improve quality, efficiency, choice, and access to care for persons with a progressive life-threatening illness through timely response to changing patient needs and conditions through the continuum of care.

In 2007, the Network established five work groups to:

- align Central LHIN's initiatives with the provincial End-of-Life Strategy
- identify educational needs of health service providers,
- develop communication tools,
- plan a 10-bed hospice for York Region,
- plan multi-disciplinary teams,
- identify integration activities to support consistent quality services, and
- develop an evaluation framework for the Network.

These initiatives are ongoing and will continue through 2008.

Health Service Needs Assessment and Gap Analysis

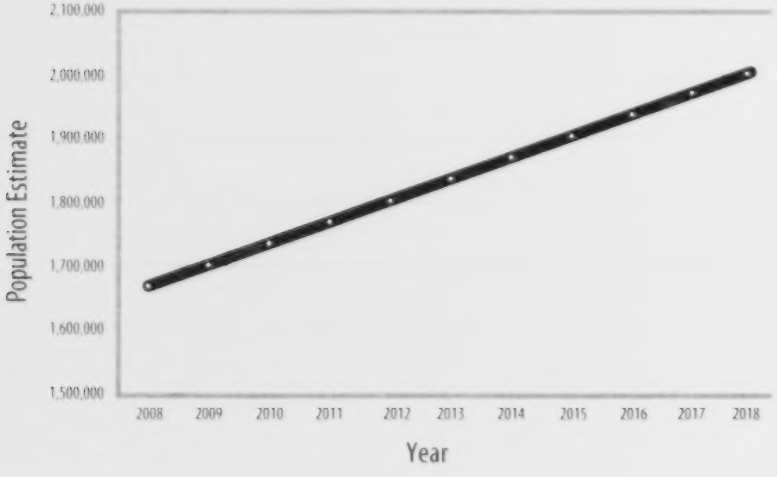
In response to unique local challenges such as our accelerated population growth, aging population and the diversity in our LHIN, in spring 2008, Central LHIN took a proactive approach by launching a service needs assessment and gap analysis to help us be more strategic in managing existing health needs in our LHIN and planning for future ones. The project will unfold in several parts in the coming months:

- first we will assess the current health service needs of our communities, and identify existing gaps,
- next we will project our growth and demographics 10 years down the road to determine where the highest needs will be, and for what specific services,
- finally, we will gauge our capacity to provide those services.

Looking at the difference between what services we will require and what we can presently provide will show us the gap we need to address to ensure the needs of our LHIN's population continue to be met.

As it does with all of our initiatives, community engagement plays a big part in this project, through "key informant" interviews with health system leaders, focus groups with our advisory groups, service providers and community representatives, and an engagement process to validate our results.

Projected Population Growth in Central LHIN 2008-2018



Integration Activities

Promoting and supporting integration

A key aspect of the mandate of LHINs is to promote integration in the health system as a means to improve the health of the people of Ontario. Integrated health systems provide coordinated, accessible and high quality health care that focuses on client needs, improves patient care and makes service delivery more efficient.

In the past year, the Central LHIN developed several documents to support integration and transparency in decision making, and to assist health service providers when developing integration proposals to understand both what integration is and how their integration request will be evaluated:

- The Guidelines for Identifying Integration define integration under the Local Health System Integration Act, 2006, and provide a list of questions that health service providers need to ask themselves when trying to determine if the Act applies to their initiative.
- The Integration Pre-Proposal Template provides a vehicle for health service providers to identify a potential integration initiative to the Central LHIN, without initiating any timeframes under the legislation. It also prompts health service providers to identify how the integration initiative is in the public interest, and how it meets the Central LHIN system goals of access, coordination, quality, and efficiency.
- The Decision Process and Criteria provides information enabling health service providers to align their proposals with the direction and priorities of the LHIN.

All of these documents are available on our website at: **www.centrallhin.on.ca**

"An integrated health system would result in coordinated health services that both improve accessibility and allow people to move more easily through the care and treatment continuum AND provide appropriate effective and efficient health services."

A first of its kind integration

In early 2008, Central LHIN saw the outcome of its first substantive voluntary integration request as St. John's Rehab and North York General Hospital realigned their delivery of rehabilitation services, to a specialized program at St. John's. The collaboration ensures patients benefit from the expertise of St. John's team, and frees up resources so North York General can admit more patients and reduce emergency department wait times.

Meeting our Performance Goals

Historically, it's been said that making changes to our healthcare system and getting results that reflect a positive return on investment requires vigilance. Our work to date has convinced us that although we must remain focused on our priorities, positive change is possible. Over the past year, we have measure the investments made in Central LHIN and are reflected below:

LHIN Scorecard released by MOHLTC on February 15, 2008

	(A)	(B)	(C)
Performance Indicator	Provincial Benchmark	LHIN Performance Target - 2007/08	Actual Performance
90th Percentile Wait Times for Cancer Surgery [1,2]	84	60	58.00
90th Percentile Wait Times for Cardiac By-Pass Procedures [1,2]	182	63	83.20
90th Percentile Wait Times for Cataract Surgery [1,2]	182	182	103.00
90th Percentile Wait Times for Hip Replacement [1,2]	182	275	168.00
90th Percentile Wait Times for Knee Replacement [1,2]	182	325	195.00
90th Percentile Wait Times for Diagnostic MRI Scan [1,2]	28	85	85.00
90th Percentile Wait Times for Diagnostic CT Scan [1,2]	28	61	56.00
Median Wait Time to Long-Term Care Home Placement-All Placements [2,3]	NA	Maintain or Improve from B/L	57.00

Note:

1 – Performance corridor calculated based on LHIN Projected Performance Target

2 – The actual Performance value is from Q2 2007/08 (Jul, Aug, & Sep 2007 Data

3 – Performance corridor calculated based on LHIN baseline

Status Legend

- On-track
- Slightly off-track
- Off-track

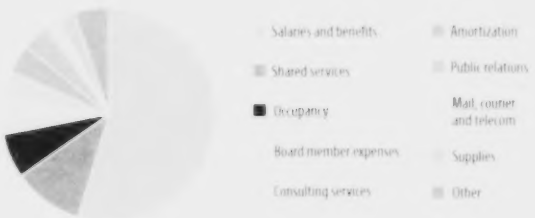
Central LHIN's Operational Performance

The Central LHIN Operating budget for 2007-08 was made up of two components:

- $3.56 million for Operations
- $0.979 million for Special Projects

Operations

The Operations budget of $3.56 million was fully spent. The chart below shows the ten major categories of expenditures for the Central LHIN. The majority of expense was in the Salaries and Benefits Category. The second largest expense is for the LHIN Shared Services Office which provides payroll, technology and legal services to each of the 14 LHINs.



Special Projects

The Central LHIN also received one-time funding to undertake planning and development for six Special Projects during the 2007-08 fiscal year. This project funding was fully spent for:

e-Health	275,000
Aging at Home	263,000
Aboriginal Initiative	10,000
Vaughan Hospital Services Study	350,000
Governance Toolkit	50,000
Emergency Department Lead	31,300
Total	979,300

Funding for a seventh project, Wait Time Funding, in the amount of $70,000, was received too late in the year to allow for project planning and implementation. This funding will be returned to the Ministry.

Highlights, Initiatives and Achievements: The Year in Review

A Year in Central LHIN: Highlights April 2007 – March 2008

APRIL 2007

- Ontario's 14 LHINs receive full funding authority and responsibility for managing significant health service delivery budgets, and the service agreements of their health service providers.
- Central LHIN approves terms of reference for: Neurological Services Advisory Network, Palliative and End-of-Life Care Transition Steering Committee, Wait Times Strategic Planning Group and Chronic Disease Management and Prevention Advisory Network, and successor group terms of reference for the Seniors Advisory Network, and Mental Health and Addictions Network.

MAY 2007

- The Central LHIN Health Human Resources Advisory Group showcases our 10-priority project for fostering healthcare renewal at the Celebrating Innovations Expo.
- Central LHIN hosts diversity training for staff, and a diversity and inclusion workshop for 140 health service providers, to discuss the importance of health care inclusion in ethnically, geographically and socio-economically diverse communities.

JUNE 2007

- The first voluntary integration request, from the Canadian Hearing Society and Deaf Access Simcoe to co-locate offices in Barrie, Ontario is accepted.
- Central LHIN Board approves the proposed amendments to the 2007-2010 Ministry/LHIN Accountability Agreement (MLAA), first approved by the Board on March 27, 2007, co-developed by the MOHLTC and LHINs to define the expected outcomes and reporting requirements for a range of accountabilities on the part of both organizations.
- The Central LHIN Board supports in principle the IHSP Implementation Framework.

JULY 2007

- Central LHIN partners with the Vaughan Healthcare Foundation to strike a working group to develop the service needs assessment for hospital services in Vaughan.
- Central LHIN develops and approves an Integration Decision Pre-Proposal Template to support health service providers as they work towards integration initiatives.
- Board supports development of a Central LHIN Palliative Care and End-of-Life Care Network to promote service innovation, integrate service delivery and improve hospice palliative care.

AUGUST 2007

- Central LHIN submits first Annual Service Plan to the Ministry of Health and Long-Term Care. The plan covers 2008-11, and serves as the operational plan for the LHIN's activities.
- Under the provincial Aging at Home strategy, Central LHIN receives $106.7 million in funding over three years to support initiatives to help seniors live independently and longer in their own homes. This initiative marks the first time the new Health Based Allocation Model is applied to determine LHIN funding allocations.

SEPTEMBER 2007

- In a day-long collaborative kick-off session, Central LHIN begins its first ever hospital annual planning submission (HAPS) process with its seven public hospitals.
- Doorways to Care – a system navigation model designed to help seniors and their care givers access care and services more easily – becomes the first initiative under our IHSP to receive funding approval for planning and implementation.

OCTOBER 2007

- Phase two of an e-referral pilot program begins in Central LHIN, with the aim of supporting single plan of care for shared clients through a system of integrated and co-ordinated care across health system providers.

- Central LHIN submits a high-level Directional Plan for Aging at Home to the MOHLTC.
- Board approves funding allocation to support the implementation of the Mental Health and Addiction Cultural Competency Project
- Board approves one-time funding to support the implementation of the health professionals self-management workshop

NOVEMBER 2007

- The voluntary integration request from St. John's Rehab and North York General Hospital, to realign the delivery of rehabilitation services to a specialized program at St. John's is accepted. Collaboration ensures patients benefit from St. John's expertise, and frees up resources so North York General Hospital can admit more patients and reduce emergency department wait times.
- Central LHIN enters into an agreement with Toronto Central LHIN to collaborate on a joint eHealth program.
- Central LHIN approves the Hospital Service Accountability Agreement template to be used by its health service providers to outline mutual responsibilities between our organization and theirs.

DECEMBER 2007

- Board of Directors approves the final slate of projects under the Urgent Priorities funding announced by the MOHLTC in October, finalizing allocation of our $2 million allotment.
- The Diversity and Inclusion Advisory Committee, formed to bring together individuals from all geographic sectors, cultures and age groups within Central LHIN to plan initiatives to address health service disparities related to diversity, meets for the first time.
- Approval of the transfer of 1,000 cataract cases and one-time funding from Humber River Regional Hospital to North York General Hospital and the allocation of funding from the LHIN Urgent Priorities Fund to Humber River Regional Hospital for additional surgical procedures.
- Four other LHINs join Central LHIN, along with health service provider and MOHLTC representatives to develop a LHIN-Health Service Provider Governance Toolkit.

JANUARY 2008

- Central LHIN hosts an MPP breakfast – to share information with our fourteen members of parliament.
- Central LHIN approves the slate of candidates and final terms of reference for the Health Professional Advisory Committee.
- Central LHIN Board approves 2007-08 Hospital High Growth and Flo collaborative funding allocations.

FEBRUARY 2008

- 150 Central LHIN seniors, caregivers, and seniors' associations participate in a province-wide Aging at Home videoconference, to share ideas around innovative supports and services for seniors in the community setting.
- Central LHIN submits its Aging at Home Detailed Service Plan and slate of projects to the MOHLTC.
- The acceptance of Markham-Stouffville, Southlake Regional and York Central hospitals voluntary integration proposal to join the Central Ontario Health Purchasing Alliance.

MARCH 2008

- Central LHIN hosts 167 Central LHIN health service providers at a one-day Leadership Summit to talk about how to work together to implement the HSP.
- As part of the Central LHIN's first ever hospital annual submission planning (HAPS) process, our Board approves the HAPS submissions of three of our hospitals.
- Central LHIN submits its report *Service Needs Assessment for Identification of Vaughan Hospital Services* to the MOHLTC.
- Central LHIN initiates a health service needs assessment and gap analysis to determine current and future health needs in our LHIN, and to better plan how to meet those needs.
- The acceptance of North York General Hospital's voluntary integration request to join the Council of Academic Hospital's of Ontario Capital Equipment Group Purchasing Initiative.

Deloitte

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Auditors' Report

To the Members of the Board of Directors of the
Central Local Health Integration Network

We have audited the statement of financial position of the Central Local Health Integration Network (the "LHIN") as at March 31, 2008 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Central Local Health Integration Network as at March 31, 2008 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 1, 2008

Central Local Health Integration Network

Statement of financial position
as at March 31, 2008

	2008	2007
	$	$
Financial assets		
Cash	**671,821**	311,559
Due from Ministry of Health and Long-Term Care ("MOHLTC")	**3,054,920**	-
Accounts receivable	**2,725**	232
	3,729,466	311,791
Liabilities		
Accounts payable and accrued liabilities	**601,969**	279,936
Due to MOHLTC (Note 3b)	**70,733**	428
Due to Health Service Providers ("HSPs")	**3,054,920**	-
Due to the LHIN Shared Services Office (Note 4)	**1,844**	34,917
Deferred capital contributions (Note 5)	**303,746**	360,436
	4,033,212	675,717
Commitments (Note 6)		
Net debt	**(303,746)**	(363,926)
Non-financial assets		
Prepaid expenses	**-**	3,490
Capital assets (Note 7)	**303,746**	360,436
	303,746	363,926
Accumulated surplus	**-**	-

Approved by the Board

Central Local Health Integration Network

Statement of financial activities

year ended March 31, 2008

	Budget (unaudited) (Note 8)	2008 Actual	2007 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**1,468,249,564**	**1,493,039,609**	-
Operations of LHIN	**3,460,603**	**3,436,912**	3,012,028
E-Health (Note 10a)	-	**275,000**	32,000
End of Life funding (Note 10b)	-	-	70,000
Aging at Home Funding (Note 10c)	-	**263,000**	-
Aboriginal Initiative (Note 10d)	-	**10,000**	-
Vaughan Hospital Study (Note 10e)	-	**350,000**	-
Governance Toolkit (Note 10f)	-	**50,000**	-
Emergency Department Lead (Note 10g)	-	**31,300**	-
Wait Time Funding (Note 10h)	-	**70,000**	-
Amortization of deferred capital contributions (Note 5)	-	**120,381**	102,780
	1,471,710,167	**1,497,646,202**	3,216,808
Expenses			
Transfer payments to HSPs (Note 9)	**1,468,249,564**	**1,492,904,011**	-
Operations			
General and administrative (Note 11)	**3,460,603**	**3,556,988**	3,114,489
E-Health (Note 10a)	-	**275,000**	31,979
End of Life funding (Note 10b)	-	-	69,912
Aging at Home Funding (Note 10c)	-	**263,000**	-
Aboriginal Initiative (Note 10d)	-	**10,000**	-
Vaughan Hospital Study (Note 10e)	-	**350,000**	-
Governance Toolkit (Note 10f)	-	**50,000**	-
Emergency Department Lead (Note 10g)	-	**31,300**	-
	1,471,710,167	**1,497,440,299**	3,216,380
Annual surplus before funding repayable to the MOHLTC	-	**205,903**	428
Funding repayable to the MOHLTC regarding HSPs transfer payments (Note 3a)	-	**(135,598)**	-
Funding repayable to the MOHLTC regarding operations (Note 3a)	-	**(70,305)**	(428)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Central Local Health Integration Network

Statement of changes in net debt

year ended March 31, 2008

	2008	2007
	$	$
Annual surplus	-	-
Acquisition of capital assets	**63,691**	78,636
Amortization of capital assets	**(120,381)**	(102,780)
Change in other non-financial assets	**(3,490)**	3,490
Decrease in net debt	**(60,180)**	(20,654)
Opening net debt	**363,926**	384,580
Closing net debt	**303,746**	363,926

Central Local Health Integration Network

Statement of cash flows
year ended March 31, 2008

	2008	2007
	$	$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**(120,381)**	102,780
Amortization of deferred capital contributions (Note 5)	**120,381**	(102,780)
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC	**(3,054,920)**	-
Increase in accounts receivable	**(2,493)**	(232)
Increase in accounts payable	**322,033**	279,936
Increase (decrease) in due to the MOHLTC	**70,305**	(32,948)
Increase in due to HSPs	**3,054,920**	-
Decrease (increase) in due to the LHIN Shared Services Office	**(33,073)**	34,917
Decrease (increase) in prepaid expenses	**3,490**	(3,490)
	360,262	278,183
Capital transactions		
Acquisition of capital assets	**(63,691)**	(78,636)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**63,691**	78,636
Net increase in cash	**360,262**	278,183
Cash, beginning of year	**311,559**	33,376
Cash, end of year	**671,821**	311,559

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

1. Description of business

The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and the amounts transferred to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2008.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Expenses include non-cash items, such as the amortization of capital assets; and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital asset purchases, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	Surplus	
	$	$	$	
Transfer payments to HSPs	**1,493,039,609**	**1,492,904,011**	**135,598**	*
LHIN operations	**3,557,293**	**3,556,988**	**305**	
Special Program Funding	**1,049,300**	**979,300**	**70,000**	
	1,497,646,202	**1,497,440,299**	**205,903**	

The transfer payment to HSPs surplus represents under-expenditure held at the MOHLTC on behalf of the LHIN.

b. The amount due to the MOHLTC at March 31 is made up as follows:

	2008	2007
	$	$
Due to MOHLTC, beginning of year	**428**	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**70,305**	428
Due to MOHLTC, end of year	**70,733**	428

* Transfer Payment funding of $135,598 was not fully allocated. The $135,598 is made up of the following: $18,245 unallocated funding for the Urgent Priorities Initiative and $117,335 unallocated in year recoveries from HSPs. Since the cash related to the transfer payment to HSPs does not flow through the LHIN, the transfer payment funding for the above cannot be owed back to the MOHLTC.

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

5. Deferred capital contributions

	2008	2007
	$	$
Balance, beginning of year	**360,436**	384,580
Capital contributions received during the year	**63,691**	78,636
Amortization for the year	**(120,381)**	(102,780)
Balance, end of year	**303,746**	360,436

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next four years and thereafter are as follows:

	$
2009	253,987
2010	257,798
2011	257,798
2012 and thereafter	-

The LHIN also has funding commitments to certain HSPs associated with accountability agreements. Minimum commitments to HSPs relate to the next two years, based on the current accountability agreements as follows:

	$
2009 Hospital funding	946,282,094
2010 Hospital funding	966,873,094

7. Capital assets

	Cost	Accumulated amortization	2008 Net book value	2007 Net book value
	$	$	$	$
Office furniture and fixtures	**191,396**	**95,731**	**95,665**	105,218
Computer equipment	**33,873**	**10,065**	**23,808**	3,091
Leasehold improvements	**397,785**	**213,512**	**184,273**	237,589
Web development	-	-	-	14,538
	623,054	**319,308**	**303,746**	360,436

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2007. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,493,039,609 is made up of the following:

	$
Initial budget	**1,468,249,564**
Adjustments due to announcements made during the year	**24,790,045**
	1,493,039,609

The total budget by sector is as follows:	
Operation of Hospitals	**950,703,712**
Grants for Municipal Taxation	**216,450**
Long Term Care Homes	**256,892,671**
Community Care Access Centres	**171,819,908**
Community Support Services (incl. ABI)	**33,219,047**
Assisted Living Services in Supportive Housing	**18,241,600**
Community Health Centres	**4,524,938**
Community Mental Health	**53,517,250**
Addictions Program	**3,904,033**
Total budget	**1,493,039,609**

The original operating budget was $3,460,603. Additional program funding in year resulted in a year-end budget of $4,606,593 made up of the following:

		$
Initial budget as reported on the statement of financial activities		**3,460,603**
Additional funding received in-year:		
Rent adjustment		**40,000**
Funding for capital asset purchased transferred to deferred capital contributions		**(63,691)**
Funding transferred from deferred capital contributions		**120,381**
Special programs		
e-health	**275,000**	
Governance toolkit	**50,000**	
Aboriginal engagement	**10,000**	
Wait time funding	**70,000**	
Vaughan hospital study funding	**350,000**	
Aging at home	**263,000**	
Emergency department lead	**31,300**	**1,049,300**
Closing Budget		**4,606,593**

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,493,039,609 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2008 as follows:

	$
Operation of Hospitals	**952,972,962**
Grants to compensate for Municipal Taxation - Public Hospitals	**216,450**
Long Term Care Homes	**256,892,671**
Community Care Access Centres	**170,737,908**
Community Support Services	**33,803,924**
Assisted Living Services in Supportive Housing	**18,271,900**
Community Health Centres	**3,300,771**
Community Mental Health	**52,782,133**
Addictions program	**3,925,292**
	1,492,904,011

The LHIN did not authorize any funding to HSPs in fiscal 2007.

10. a) E-health

The LHIN received funding of $275,000 (2007 - $32,000) related to the E-health project. E-health expenses incurred during the year are as follows:

	2008	2007
	$	$
Salaries and benefits	**163,585**	-
Consulting services	**103,875**	25,750
Supplies	**2,042**	1,062
Other	**5,498**	5,167
	275,000	31,979

b) End of life

The LHIN received no funding for the End of Life project in the 2008 fiscal year (2007 - $70,000). The following are the expense details from last fiscal year:

	2008	2007
	$	$
Consulting services	-	60,303
Supplies	-	5,032
Other	-	4,577
	-	69,912

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

10. c) Aging at Home

The LHIN received funding of $263,000 (2007 - $Nil) related to the Aging at Home initiative. Aging at Home expenses incurred during the year are as follows:

	2008	2007
	$	$
Salaries and benefits	**93,783**	-
Public relations	**17,279**	-
Consulting services	**142,586**	-
Supplies	**929**	-
Other	**8,423**	-
	263,000	-

d) Aboriginal initiative

The LHIN received funding of $10,000 (2007 - $Nil) related to the Aboriginal project. The funding was fully spent on consulting services in the 2008 fiscal year.

e) Vaughan hospital study project

The LHIN received funding of $350,000 (2007 - $Nil) related to the Vaughan hospital study project. Vaughan hospital study project expenses incurred during the year are as follows:

	2008	2007
	$	$
Salaries and benefits	**158,765**	-
Occupancy	**7,342**	
Public relations	**5,900**	-
Consulting services	**172,174**	-
Supplies	**791**	-
Other	**5,028**	-
	350,000	-

f) Governance toolkit

The LHIN received funding of $50,000 (2007 - $Nil) from the MOHLTC towards a multi-LHIN project related to the creation of a Governance Toolkit. The Funding was primarily spent on consulting services.

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

10. g) Emergency department (ED) lead project

The LHIN received funding of $31,300 (2007 - $Nil) related to the ED Lead project. ED Lead project expenses incurred during the year are as follows:

	2008	2007
	$	$
Salaries and benefits	**6,000**	-
Consulting services	**25,000**	-
Supplies	**300**	-
	31,300	-

h) Wait time funding

The LHIN received funding of $70,000 (2007 - $Nil) related to the Wait Time funding project. The funds were provided late in the year. There was insufficient time to undertake this Project in this fiscal year. The funding is being returned to the MOHLTC in its entirety.

11. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2008	2007
	$	$
Salaries and benefits	**2,241,011**	1,415,446
Occupancy	**237,268**	124,540
Amortization	**120,381**	102,780
Shared services	**300,000**	294,071
Public relations	**116,301**	269,329
Consulting services	**128,474**	608,219
Supplies	**46,961**	58,036
Board member expenses	**140,676**	123,828
Mail, courier and telecommunications	**56,381**	32,489
Other	**169,535**	85,751
	3,556,988	3,114,489

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 27 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2008 was $160,859 (2007 - $74,254) for current service costs and is included as an expense in the Statement of Financial Activities.

Central Local Health Integration Network

Notes to the financial statements
March 31, 2008

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

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